OFFICE OF SPECIAL MASTERS
No. 06-118V
October 12, 2006
Not to be Published

MICHAEL J. HUDSON,	*	
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Petitioner,	*	
	*	
v.	*	Entitlement decision; flu vaccine
	*	followed five months later by
SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,	*	brachial plexopathy; no causation
	*	
Respondent.	*	

Nicole V. Gurkin, New York, NY, for petitioner.
Michael P. Milmoe, Washington, DC, for respondent.

MILLMAN, Special Master

DECISION[1]

Petitioner filed a petition on February 17, 2006, under the National Childhood Vaccine Injury Act, 42 U.S.C. § 300aa-10 et seq., alleging that a flu vaccination he received on November

[1] Because this unpublished decision contains a reasoned explanation for the special master's action in this case, the special master intends to post this unpublished decision on the United States Court of Federal Claims's website, in accordance with the E-Government Act of 2002, Pub. L. No. 107-347, 116 Stat. 2899, 2913 (Dec. 17, 2002). Vaccine Rule 18(b) states that all decisions of the special masters will be made available to the public unless they contain trade secrets or commercial or financial information that is privileged and confidential, or medical or similar information whose disclosure would clearly be an unwarranted invasion of privacy. When such a decision or designated substantive order is filed, petitioner has 14 days to identify and move to delete such information prior to the document's disclosure. If the special master, upon review, agrees that the identified material fits within the banned categories listed above, the special master shall delete such material from public access.

20, 2001, caused him bilateral brachioplexitis. Although he alleged an onset of days after vaccination, numerous histories he gave to doctors contemporaneously with his symptoms show that onset of his condition occurred five months after vaccination.

At a status conference on October 6, 2006, petitioner's counsel stated she would not be filing a medical expert report, having failed to obtain expert medical opinion in support of petitioner's allegations, and asked for judgment on the record.

FACTS

Petitioner was born on June 13, 1948.

On February 23, 1995, petitioner saw Dr. Gary P. Francke because of problems with his left shoulder and left upper extremity that he had been experiencing for two months. It hurt to lift his shoulder and he had discomfort in the area of his deltoid tendon and lateral portion of his elbow. He had some vague numbness on the back of his long and ring fingers. He felt tired. He was tender over the insertion of the deltoid muscle onto the upper middle of the humerus bone. He was tender over the left lateral epicondyle and short common extensor tendon area. He had mild paresthesia over the front of the biceps and in between the long and ring finger on the left side. Dr. Francke's diagnosis was radicular symptoms, and tendinitis of the deltoid muscle and lateral epicondyle area. Med. recs. at Ex. 1, p. 10.

Over six years later, on November 20, 2001, at 10:00 a.m., petitioner received influenza vaccine. Med. recs. at Ex. 3.

More than five months after his vaccination, on May 8, 2002, petitioner went to see a chiropractor, Dr. Whitaker, for a condition whose onset was 18 hours before. Med. recs. at Ex. 4, pp. 1, 6. He had throbbing, burning pain in his arms which started the prior evening at dinner.

The pain was intense into the left arm into the fingertips with twitching in the left biceps. Then the pain moved to the right arm and elbow. He had neck pain on lateral bend to the opposite side. He had one hour of sleep. He took showers most of the evening. He had limited motion raising his arms. He had lifted cases of soda four days before for the Big Lake Marathon and a heavy box of mail the day before. Med. recs. at Ex. 4, p. 7.

On May 10, 2002, petitioner went to the Lake Region General Hospital ER, where he told Dr. Andrew Kane that he was feeling unwell and had weakness, pain in his right shoulder, paresthesias, decreased sleep for three days, and chills. His appetite was okay. Med. recs. at Ex. 2, p. 47.

Also, on May 10, 2002, Dr. Kane took a history and physical. Petitioner denied any chronic illness. He had tingling in his fingers and hands, and sharp pain in his left shoulder for the prior two days. He was feeling generally weak and had difficulty picking things up. He had had chills. His appetite was good. He slept without difficulty. He had had no myalgias or arthralgias. He was afebrile. Med. recs. at Ex. 2, p. 47.

Petitioner's right shoulder was tender to palpation but had full range of movement. His extremities were within normal limits. The diagnosis was paresthesias of undetermined cause, right shoulder pain. Med. recs. at Ex. 2, p. 52.

On May 22, 2002, petitioner saw Dr. Francke, complaining of pain in his arms that began about May 6, 2002, or five and one-half months after his flu vaccination. Petitioner stated he was working all day long and remembered lifting one tray of mail which was exceptionally heavy. He did not have pain in lifting it. Before dinner, when he rose to get a beer, he felt a sudden pain across his shoulders out into the lateral upper arm area on both sides, which was

very severe. Med. recs. at Ex. 1, p. 15. He had a lot of trouble sleeping and using his arms. He had had no medical illnesses. *Id.* On physical examination, petitioner had a burning sensation in the back of his palms and serious weakness in his upper extremities. The sensation in his arms appeared to be normal. Med. recs. at Ex. 1, p. 16.

One week later, on May 29, 2002, petitioner saw Dr. Christopher L. Martino, a neurologist and electromyographer, stating that the difficulties with his arms began four weeks previously (or five months after his flu vaccination). He had sudden pain in his left arm which he noted near the biceps and triceps. This became worse through the evening. He was up a significant portion of the night. He noted left hand swelling and redness to the color of the left upper limb over the next 24 hours. He had tightness and pain in his forearm. He had pain in the left trapezius area. The next day, the pain went to the right proximal limb girdle and shoulder. It became more severe, and alternated in the right and left side but not both sides together. He lost muscular power in both upper extremities. He had bilateral exercise intolerance. His sleep significantly diminished over 10 days. About three weeks after this began, he developed loss of dexterity with his hands, causing some inability to attain activities of daily living. Two weeks previously, he had a rash on his right flank which was gradually fading. He had a history of a viral illness three years previously when he became diffusely weak, sweaty, and nauseated. He finally overcame it. Med. recs. at Ex. 7, p. 1.

On physical examination, petitioner had a rash over his right flank with focal areas of pimpled appearance, but no whiteheads. It did not follow a dermatologic distribution. It did not itch. On motor examination, petitioner had severe limitation of the power of abduction. He had 2/5 or less capability in his deltoid. His biceps had 3/5 power on the left and 4/5 on the right.

His triceps had power of 4/5 on the right and were absent on the left. His left flexor pollicis longus did not work at all. His deep tendon reflexes were a trace in the biceps and absent in the triceps. He had 2+/4 in his knees and 1+/4 in his ankles. Electrical studies showed gross denervation in the bilateral deltoid and a severe loss of function of his left triceps. Remarkably, his sensory functions and nerve conductions looked very good. Dr. Martino's impression was peripheral neuropathy with proximal predilection bilaterally. Petitioner's acute peripheral neuropathy might be associated with a vasculitis and the rash might be related. There was no evidence of peripheral change or conduction block. The paroxysmal onset and severity of illness in that short period of time spoke against a motor neuron condition. There was the issue of axonal Guillain-Barré syndrome, but the evolution and localization of petitioner's syndrome spoke against that as well. Med. recs. at Ex. 7, p. 2.

The EMG and nerve conduction studies done on May 29, 2002 showed relatively intact nerve conduction. There was no evidence of a motor conduction block. Sensory velocities were mildly slow. The EMG showed gross denervation in bilateral deltoids and the left triceps. The diagnosis was patchy, largely motor axonal process and mild sensory nerve conduction changes suggesting a mixed nerve and not a pure motor illness. Med. recs. at Ex. 7, p. 4. Petitioner was now four weeks into his illness. *Id.*

On May 31, 2002, petitioner had a skin right trunk biopsy. This did not show evidence of a true vasculitis. The diagnosis was superficial perivascular lymphocytic dermatitis. Med. recs. at Ex. 2, p. 64.

On June 5, 2002, Dr. Martino noted that petitioner had marked improvement of his arm pain while on Neurontin. His diagnosis was likely idiopathic brachial plexitis. He had

occasional shoulder discomfort, clumsiness of hands, and weakness. A skin biopsy did not show vasculitis. Med. recs. at Ex. 7, p. 5.

On July 1, 2002, Dr. Martino noted petitioner had decreased amount of pain in both upper extremities. He still had proximal muscle weakness and numbness in his upper extremities, proximally in the left, distally in the right. He had bilateral brachial plexopathy (idiopathic brachioplexitis or Parsonage Turner syndrome). He was stable. He had an unusual bilateral distribution. Med. recs. at Ex. 7, p. 7.

On July 30, 2002, petitioner filled out Standard Form 3112A (Applicant's Statement of Disability for Retirement), in which he answered the question of when he became disabled with the answer: 5/3/02. Med. recs. at Ex. 7, p. 12.

On August 29, 2002, Dr. Martino noted that petitioner believed his left lower extremity had a brief paresthesia which had abated. Dr. Martino was unsure what this was about. Perhaps it was a lumbar spinal issue. Brachial plexopathy should not extend to the lower limbs. On motor examination, petitioner's lower extremities had 5/5 strength. His upper extremities were weak. His left triceps had 3/5 strength. His sensory exam showed his lower extremities were normal, but he had a patchy decrease in them. Med. recs. at Ex. 7, p. 11.

On January 13, 2002, petitioner saw Dr. H. Richard Tyler. He told Dr. Tyler that in April 2002, he had a sudden pain in his neck, shoulders, and hands. He developed brachial amyotrophy and could not lift his arms above his waist. By June, he could lift them to his chest and slowly was getting better. About August 2002, petitioner noticed his left leg dragged. He had a sensation in the back of his head. Cold weather made him worse and he had trouble walking. When he went to California, which was warm, he was totally well. He had a slight

memory problem. Occasionally, he had what he called numbness. All this seemed to follow a flu shot which was administered four to five months before his symptoms. The person in line before petitioner to receive a flu vaccination got Guillain-Barré syndrome. The person behind him had three episodes of cardiac arrest. For the last four months, petitioner had a decrease in vision. His mental status was normal. His recent, remote, and immediate recalls were normal. He had a very small proximal weakness in his biceps and triceps. He could raise his arms above his head. He performed normally and walked normally. His reflexes were all diminished. His sensory examination was normal. He had residual of brachial amyotrophy. It was not clear what this new cold sensitive phenomenon was. It sounded paramyotonic (muscle spasms caused by a disorder of muscle tonicity).[2] Med. recs. at Ex. 5, p. 1.

On January 28, 2003, Dr. Tyler stated that petitioner saw Dr. Steven A. Greenberg that day, who felt he had a recovering neuritis and most of his cold sensitive symptoms were related to that. His general review system was otherwise normal. The residua in the upper extremities were even better than when Dr. Tyler saw petitioner last. Med. recs. at Ex. 5, p. 22.

Also, on January 28, 2003, Dr. Greenberg performed an electromyography and nerve conduction studies on petitioner which proved to be abnormal. His right lateral antibrachial cutaneous SNAP was absent and his EMG was abnormal. Dr. Greenberg's impression was right brachial plexopathy with predominant involvement of the lateral cord. The presence of reinnervation suggested this was not an acute event. Med. recs. at Ex. 5, pp. 23, 24.

Also on January 28, 2003, petitioner saw Dr. Peter Q Warriner and Dr. Greenberg. Petitioner changed his history to reflect that he had received an inoculation in his left arm a few

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[2] Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 1367.

days (rather than five months) before the onset of his symptoms. Med. recs. at Ex. 6, p. 1. He stated that, in April 2002, he had a sudden onset of a sharp pain in his back in the area between his shoulder blades after attempting to lift something from the floor. Within two to three days, the pain spread to include both shoulders and he had limp muscles throughout both arms proximally and distally. A week or two afterwards, the pain subsided, but both arms felt numb. By August 2, 2002, he was not on medication. He said cold weather significantly influenced his symptoms. He had muscle stiffness and dull aching, but no significant weakness. *Id.* Most probably, he had acute brachial neuritis "in association with the vaccination." Med. recs. at Ex. 6, p. 2.

DISCUSSION

To satisfy his burden of proving causation in fact, petitioner must offer "(1) a medical theory causally connecting the vaccination and the injury; (2) a logical sequence of cause and effect showing that the vaccination was the reason for the injury; and (3) a showing of a proximate temporal relationship between vaccination and injury." Althen v. Secretary of HHS, 418 F. 3d 1274, 1278 (Fed. Cir. 2005). In Althen, the Federal Circuit quoted its opinion in Grant v. Secretary of HHS, 956 F.2d 1144, 1148 (Fed. Cir. 1992):

> A persuasive medical theory is demonstrated by "proof of a logical sequence of cause and effect showing that the vaccination was the reason for the injury[,]" the logical sequence being supported by "reputable medical or scientific explanation[,]" *i.e.*, "evidence in the form of scientific studies or expert medical testimony[.]"

In Capizzano v. Secretary of HHS, 440 F.3d 1317, 1325 (Fed. Cir. 2006), the Federal Circuit said "we conclude that requiring either epidemiologic studies, rechallenge, the presence of pathological markers or genetic disposition, or general acceptance in the scientific or medical

communities to establish a logical sequence of cause and effect is contrary to what we said in Althen...."

Close calls are to be resolved in favor of petitioners. Capizzano, supra, at 1327; Althen, supra, at 1280. *See generally*, Knudsen v. Secretary of HHS, 35 F.3d 543, 551 (Fed. Cir. 1994).

Without more, "evidence showing an absence of other causes does not meet petitioners' affirmative duty to show actual or legal causation." Grant, supra, at 1149. Mere temporal association is not sufficient to prove causation in fact. Hasler v. US, 718 F.2d 202, 205 (6th Cir. 1983), cert. denied, 469 U.S. 817 (1984).

Petitioner must show not only that but for the vaccine, he would not have had brachial plexopathy, but also that the vaccine was a substantial factor in bringing about his brachial plexopathy. Shyface v. Secretary of HHS, 165 F.3d 1344, 1352 (Fed. Cir. 1999).

The Federal Circuit stated in Althen, supra, at 1280, that "the purpose of the Vaccine Act's preponderance standard is to allow the finding of causation in a field bereft of complete and direct proof of how vaccines affect the human body."

The Federal Circuit in Capizzano emphasized the opinions of petitioner's four treating doctors in that case. 440 F.3d at 1326.

In the instant action, petitioner has offered no evidence of causation except a statement by doctors over one year after the onset of his brachial plexopathy, when he changed the history of his symptoms and vaccination to reflect symptomatology a few days after vaccination, rather than the actual five months after vaccination, to wit, that his symptoms occurred "in association with the vaccination." But, the symptoms did not occur in association with the vaccination. All of his other histories are consistent with sudden onset of symptoms in early May, which is over five

months after his flu vaccination. In his application for retirement benefits, petitioner himself put down May 3, 2002 as the onset of his disability.

The Vaccine Act does not permit the undersigned to rule in favor of petitioner based solely upon his allegations absent confirmation from the medical records or medical opinion. 42 U.S.C. § 300aa-13(a)(1).

Petitioner has not made a prima facie case of causation in fact and his petition must be dismissed.

CONCLUSION

This petition is dismissed with prejudice. In the absence of a motion for review filed pursuant to RCFC Appendix B, the clerk of the court is directed to enter judgment in accordance herewith.[3]

IT IS SO ORDERED.

_____ _____

DATE Laura D. Millman
Special Master

[3] Pursuant to Vaccine Rule 11(a), entry of judgment can be expedited by each party's filing a notice renouncing his right to seek review.